AIM Statute

CALIFORNIA CODES
INSURANCE CODE
SECTIONS 12695-12699.05

12695. This part shall be known and may be cited as the Access for Infants and Mothers Program.

12695.02. For purposes of this part, the definitions contained in this article shall govern the construction of this part, unless the context requires otherwise.

12695.04. "Advisory panel" means the Managed Risk Medical Insurance Board Access for Infants and Mothers Advisory Panel created pursuant to Section 12696.5.

12695.06. "Applicant" means an individual who applies for coverage through the program.

12695.08. "Board" means the Managed Risk Medical Insurance Board created pursuant to Section 12710.

12695.10. "Case management" means the management of all physician services, both primary and specialty, and arrangements for hospitalization, post-discharge care, and followup care.

12695.12. "Comprehensive primary care services" include, but are not limited to, all of the following:

(a) Preventive, screening, diagnostic, and treatment services furnished directly by a licensed clinic, either onsite or by formal written contract, on a case-managed basis, to patients who remain less than 24 hours at the clinic for an illness or injury, advice, counseling, outreach, and translation as needed.

(b) Physician services.

(c) Emergency first aid, perinatal, obstetric, radiology, laboratory, and nutrition services.

(d) Services of advanced practice nurses or mid-level practitioners who are authorized to perform any of the services listed in this subdivision within the scope of their licensure.

(e) Health education, including education regarding the harmful results of tobacco use, and information and referral services.

12695.14. "Fund" means the Perinatal Insurance Fund.

12695.16. "Health education services relating to tobacco use" means tobacco use prevention and education services, including, when appropriate, tobacco use cessation services, in accordance with protocols established by the board in coordination with the Tobacco Control Section of the State Department of Health Services.

12695.18. "Participating health plan" means any of the following plans which are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:

(a) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(b) A nonprofit hospital service plan qualifying under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2.

(c) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).

(d) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(e) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Managed Health Care shall be required to meet the requirements of this part.

(f) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Managed Health Care shall be required to meet the requirements of this part.

12695.20. "Program" means the Access for Infants and Mothers Program.

12695.22. "Subscriber" means an individual who is eligible for and enrolled in the program.

12695.24. "Subscriber contribution" means the cost to the subscriber to participate in the program.

12696**.** The board shall administer the program.

12696**.**05**.** The board may do all of the following:

(a) Determine eligibility criteria for the program. These criteria shall include the requirements set forth in Section 12698.

(b) Determine the eligibility of applicants.

(c) Determine when subscribers are covered and the extent and scope of coverage.

(d) Determine subscriber contribution amounts schedules.

Subscriber contribution amounts shall be indexed to the federal poverty level and shall not exceed 2 percent of a subscriber's annual gross family income.

(e) Provide coverage through participating health plans or through coordination with other state programs, and contract for the processing of applications and the enrollment of subscribers. Any contract entered into pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of

General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed the amount appropriated for the program.

(f) Authorize expenditures from the fund to pay program expenses which exceed subscriber contributions, and to administer the program as necessary.

(g) Develop a promotional component of the program to make Californians aware of the program and the opportunity that it presents.

(h) Issue rules and regulations as necessary to administer the program. All rules and regulations issued pursuant to this subdivision that manage program integrity, revise the benefit package, or reduce the eligibility criteria below 300 percent of the federal poverty level may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government **Code**). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(i) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

12696.10. The board, in coordination with the Tobacco Control Section of the State Department of Health Services, shall develop protocols relating to health education for tobacco use. These protocols shall include, but not be limited to, all of the following:

(a) Referral to perinatal and related support services.

(b) Outreach services and assessment of smoking status.

(c) Individualized counseling and advocacy services.

(d) Motivational messages.

(e) Cessation services, if appropriate.

(f) Incentives to maintain a healthy lifestyle.

(g) Followup assessment.

(h) Maintenance and relapse prevention services.

12696.15. The board shall administer the program in a manner that ensures that program expenditures do not exceed amounts available in the fund.

12696.20. The board shall coordinate with other state agencies, as appropriate, to help ensure continuity of health care services.

12696.5. (a) The board shall appoint a seven-member advisory panel to advise the board, the chairman of which shall serve as an ex officio, nonvoting, member of the board. The panel shall be appointed and ready to perform its duties by September 1, 1991.

(b) The membership of the advisory panel shall be composed of all of the following:

(1) One physician and surgeon who is board certified in the area of gynecology and obstetrics.

(2) One physician and surgeon who is board certified in pediatrics.

(3) One physician and surgeon who is board certified in the area of family practice.

(4) One representative from the beneficiary population.

(5) One representative from a general acute care hospital with a full complement of obstetrical services.

(6) One advanced practice nurse serving in a maternal and child health capacity.

(7) One representative from a licensed nonprofit primary care clinic or from a county clinic.

(c) The panel shall elect, from among its members, its chairman.

(d) The panel shall have all of the following powers and duties:

(1) To advise the board on all policies, regulations, operations, and implementation of the Access for Infants and Mothers Program.

(2) To consider all written recommendations of the panel and respond in writing when the board rejects the advice of the panel.

(3) To meet at least quarterly, unless deemed unnecessary by the chair.

(e) The members of the panel shall be reimbursed for all necessary travel expenses associated with the activities of the panel.

(f) Those members of the panel who are economically unable to meet panel responsibilities shall be provided a per diem compensation.

12696.7. (a) The board may contract with a variety of health plans and types of health care service delivery systems in order to offer subscribers a choice of plans, providers, and types of service delivery.

(b) Participating health plans contracting with the board pursuant to this part shall provide benefits or coverage to subscribers only as determined by the board pursuant to subdivision (b) of Section 12696.05.

12697. The board may negotiate or arrange for stop-loss insurance coverage that limits the program's fiscal responsibility for the total costs of health services provided to program subscribers, or arrange for participating health plans to share or assume the financial risk for a portion of the total cost of health care services to program subscribers, or both.

12697.10. (a) The board shall include, within contracts negotiated pursuant to this part, terms regarding the cancellation of the contracts, and may cancel any contract negotiated pursuant to this part with any participating health plan as provided for in the contract.

(b) The board shall provide for the transfer of coverage of any subscriber to another participating health plan if a contract with any participating health plan under which the subscriber receives coverage is canceled or not renewed.

12697.15. (a) Each participating health plan contracting with the board pursuant to this part shall provide health education services related to tobacco use to all program participants.

(b) The education activities required by subdivision (a) shall include all of the following:

(1) Dissuading persons from beginning to smoke.

(2) Encouraging smoking cessation.

(3) Providing information on the health effects of tobacco use on the user, children, and nonsmokers.

12698. To be eligible to participate in the program, a person shall meet all of the following requirements:

(a) Be a resident of the state for at least six continuous months prior to application. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(b) (1) Until the first day of the second month following the effective date of the amendment made to this subdivision in 1994, have a household income that does not exceed 250 percent of the official federal poverty level unless the board determines that the program funds are adequate to serve households above that level.

(2) Upon the first day of the second month following the effective date of the amendment made to this subdivision in 1994, have a household income that is above 200 percent of the official federal poverty level but does not exceed 250 percent of the official federal poverty level unless the board determines that the program funds are adequate to serve households above the 250 percent of the official federal poverty level.

(c) Pay an initial subscriber contribution of not more than fifty dollars ($50), and agree to the payment of the complete subscriber contribution. A federally recognized California Indian tribal

government may make the initial and complete subscriber contributions on behalf of a member of the tribe only if a contribution on behalf of members of federally recognized California Indian tribes does not limit or preclude federal financial participation under Title XXI of the Social Security Act. If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health plan options available in the county where the member resides.

12698.05. A person shall not be eligible to participate in the program if the person is eligible for Medi-Cal without a share of cost or eligible for Medicare at the time of application.

12698.06. A person shall not be eligible to participate in the program for covered services under this part for services that are covered through private **insurance** arrangements at the time of application.

12698.15. Subscribers shall not be disenrolled for failure to pay subscriber contributions. The board may impose or contract for collection actions to collect unpaid subscriber contributions.

12698.20. (a) If a subscriber is dissatisfied with any action, or failure to act, which has occurred in connection with a participating plan's coverage, the subscriber may appeal to the board and shall be accorded an opportunity for a fair hearing. Hearings may be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code**.**

(b) The program may place a lien on compensation or benefits, recovered or recoverable by a subscriber from any party or parties responsible for the compensation or benefits, for which benefits have been provided under a policy issued under this part.

12698.25. Services that would be covered under the program that are provided to pregnant women who, after receiving those services, are subsequently determined to be eligible for coverage under this part may be reimbursed as determined by the board. In no case shall services received prior to 40 days before a woman's date of application be eligible for reimbursement.

12698.30. (a) At a minimum, coverage shall be provided to subscribers during one pregnancy, and for 60 days thereafter, and to children less than two years of age who were born of a pregnancy covered under this program to a woman enrolled in the program before July 1, 2004.

(b) Coverage provided pursuant to this part shall include, at a minimum, those services required to be provided by health care service plans approved by the Secretary of Health and Human Services as a federally qualified health care service plan pursuant to Section 417.101 of Title 42 of the Code of Federal Regulations.

(c) Coverage shall include health education services related to tobacco use.

(d) Medically necessary prescription drugs shall be a required benefit in the coverage provided under this part.

12698.35. (a) Through its courts, statutes, and under its Constitution, California protects a woman's right to reproductive privacy. California reaffirms these protections and specifically its Supreme Court decision in People v. Belous (1969) 71 Cal.2d 954, 966-68.

(b) The State Department of Health Services and the Managed Risk Medical Insurance Board may accept or use moneys under Title XXI of the federal Social Security Act (known as the State Children's Health Insurance Program or S-CHIP), as interpreted in Section 457.10 of Title 42 of the Code of Federal Regulations, to fund services for women pursuant to Section 14007.7 of the Welfare and Institutions Code (Medi-Cal) and Part 6.3 (commencing with Section 12695) (Access for Infants and Mothers (AIM)) only when, during the period of coverage, the woman is the beneficiary. The scope of services covered under Medi-Cal and AIM, as defined in statutes, regulations, and state plans, is not altered by this section or the state plan amendment submitted pursuant to this section.

(c) California's S-CHIP plan and any amendments submitted and implemented pursuant to this section shall be consistent with subdivisions (a) and (b).

(d) This section is a declaration of existing law.

12698.50. (a) (1) It shall constitute unfair competition for purposes of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code for an insurer, an insurance agent or broker, or an administrator, as defined in Section 1759, to refer an individual employee or employee's dependent to the program, or arrange for an individual employee or employee's dependent to apply to the program, for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment.

(b) Any employee described in subdivision (a) shall have a personal right of action to enforce subdivision (a).

12698.52. It shall constitute an unfair labor practice contrary to public policy, and enforceable under Section 95 of the Labor Code, for any employer to refer an individual employee or employee's dependent to the program, or to arrange for an individual employee or employee's dependent to apply to the program, for the purpose of separating that employee or employee's dependent from group health coverage provided in connection with the employee's employment.

12698.54. It shall constitute an unfair labor practice contrary to public policy and enforceable under Section 95 of the Labor Code for any employer to change the employee-employer share-of-cost ratio or to make any other modification of maternity care coverage for employees or employees' dependents that results in the enrollment of the employees or employees' dependents in the program established pursuant this part.

12698.56. For purposes of this article, "group health coverage" includes any nonprofit hospital service plan, health care service plan, self-insured employee welfare benefit plan, or disability insurance providing medical or hospital benefits.

12699. (a) The Perinatal Insurance Fund is hereby created in the State Treasury.

(b) Amounts deposited in the fund shall only be used for the purposes specified by this chapter.

(c) Notwithstanding Section 13340 of the Government Code, the fund is hereby continuously appropriated, without regard to fiscal years, to the board, for the purposes specified in this part.

12699.05. (a) The board shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions.

(b) From money appropriated by the Legislature to the fund, the board may expend sufficient funds for operating expenses incurred in carrying out this part.

(c) The board shall develop and utilize all appropriate cost containment measures to maximize the coverage offered under the program.